Life And Death And Who’s Going To Pay

As a general rule, and outside of criminal situations, I believe that you shouldn’t have to threaten one person’s life to save another’s. But the only time that I’m sure I saved someone from death, that’s exactly what I had to do.

One mild, ordinary afternoon several years ago, we had just stopped to pick up some material at our daughter’s school when a workman (an electrician, I think) came out of a house across the street and tried to climb into his van. He couldn’t do it. In fact, he couldn’t speak and could barely breathe; he appeared to be having a heart attack right there. Telling my wife to follow me in our car, I ran to the man, grabbed his keys from his hand, and hauled him into his van’s passenger seat. I sped off as quickly as traffic allowed; fortunately, we were only minutes away from a major hospital.

I drove straight to the emergency entrance, left the van in front, and, slinging the man’s arm over my shoulder, half-walked, half-dragged him into the emergency department waiting room. I slid him into a chair, where he sat gasping. Dashing up to a young receptionist sitting at the nearest desk, I told her, “I think he’s dying… probably having a heart attack… Take care of him, please,” or something close to that.

She looked up at me. Then she pulled out a pen and a paper form and started asking questions: “What’s his name? Social Security number? Address? Who’s going to pay for him? Does he have insurance?” It seemed possible that he might die, right there, while she rattled off a list of questions that I couldn’t answer. I tried to tell her that, but it didn’t seem to get through to her.

I don’t get angry easily. And never before or since that afternoon have I felt like seriously threatening another person physically. But since the receptionist wasn’t paying any attention to the life-or-death emergency slumped a few yards away from her, or to my repeated insistence that I didn’t know anything about the man, I had to try something extreme. I leaned over her, my face hardly a foot from hers,
and said, loudly enough for everyone in the waiting room to hear, “Lady, if you let him die here, you’re going to be the second person to die in this emergency room this afternoon!”

She jumped up and ran through the swinging doors at the back of the waiting area. “Great,” I thought, “now he’s going to die and I’m going to be arrested for threatening her.” But, instead, two attendants rushed out pushing a gurney, loaded the man—who by this time was turning blue—onto it, and disappeared back through the doors. The receptionist returned, looking a little pale and shaky, and sat down again.

“Look,” I said to her, talking more calmly. “I’ll tell you the only thing I know about that man, which is the number of the license plate on his van. It’s sitting in front of your emergency entrance. Here are the keys.” I added that although I didn’t know him and wasn’t responsible for him, I’d leave my name and phone number in case anyone needed to contact me.

Well, he didn’t die. And several days later he called and told me that the problem hadn’t been a heart attack. He’d undergone lung surgery recently and some of the stitches had ripped loose. When I’d seen him by his van, he was literally drowning as his lungs filled with fluid. The hospital was able to pull him through the crisis; however, if he’d collapsed next to his van without anyone seeing him, he wouldn’t have made it. And it turned out that yes, he did have insurance. He thanked me for saving his life, and we haven’t spoken since.

**What’s Wrong With This Picture?**

How was this emergency room incident even possible? Where should the blame be placed in the chaos that we jokingly refer to as the U.S. health care system? At the front end—at that receptionist’s desk—was an unresponsive, or untrained, or maybe just routine-minded young woman who, until she thought I might actually strangle her, couldn’t seem to understand what “emergency” meant. Maybe that’s the whole story: one person who didn’t get it. After all, emergency departments routinely deal with patients whose identities and insurance status are initially unknown, and staff members don’t usually waste time on questions when there are much more urgent needs.

But perhaps part of the problem originated one step further back. Behind that receptionist was an institution—a prestigious academic hospital, no less—that hadn’t succeeded in getting her to understand what her job was. Maybe it had spent too much time making sure that she could fill out forms properly and not enough time on whether she could recognize when someone might be dying right in front of her. Or she might even have been temporarily transferred from another
part of the hospital where filling out forms was essential and hadn’t shifted gears yet. I didn’t complain to anyone about how she’d behaved, and I don’t know whether she was disciplined in any way. Later, an experienced emergency physician told me that at his institution, that receptionist would have been fired.

Stepping back still further, behind that hospital was a health care system that didn’t have then—and still doesn’t have—an effective, electronic way to locate records of a person’s valuable medical facts (such as the man’s recent lung surgery). Undoubtedly his name and address were on the driver’s license in his wallet, but the key question that afternoon didn’t seem to be who he was. Rather, it was who could be billed for his treatment—if he lived long enough to be treated. And that was a key question. With a fragmented system of scores of insurers and millions of uninsured people in the United States, every mute, desperate patient is a potential economic drain whose costs, understandably, no doctor, clinic, or hospital wants to absorb. Emergency departments take that risk all the time, though; despite the health care system’s being badly broken, at least the question of payment normally comes after the question of what needs to be done for a trauma patient. Maybe the receptionist’s reaction had nothing to do with her training or the explicit definition of her job at the hospital; it just reflected the implicit systemwide pressure to collect from an insurer whenever possible.

Making The System Work

A single incident like this reveals a slice through the whole health care system, from the individual who’s the first point of contact for a sick or hurt person straight down to its concentration on who’s going to pay. Some delay and confusion and insistence on bureaucratic procedures might be admissible, even inevitable, when there is no urgency. That’s probably the case with the great majority of medical encounters. But “paper first, people second” can kill when the situation is urgent. And that’s true whether someone has insurance or not, and whether someone has the paper to prove it or not. In a paper-first health system, the insured also run the danger of having their care delayed.

A health system that works properly would never leave people so frustrated that there’d be any need to make a threat like the one I made. A health system that works properly would also include two key elements that still have not come into existence since this emergency department encounter: universal health insurance coverage, so the question of who should pay simply wouldn’t arise—at least not during an emergency—and electronic health cards that record identity and crucial medical information.

The first of these two needs—universal health insurance coverage—has been feasible for a long time, as the experience of almost every other rich country demonstrates. There might be several different major insurers (as is the case in France and Germany) or a single insurer (as in the United Kingdom), but hospitals know...
that everyone who comes through their doors is covered; the only question is where to send the bill.

Even where various supplementary forms of private insurance exist (as they do in virtually all Organization for Economic Cooperation and Development [OECD] countries), the public system still fully covers emergency care for all. The United States mostly manages to provide emergency care, but there’s no uniform system to guarantee that it happens, let alone to ensure that everyone is covered for nonemergency medical needs. In any comparison of health systems, the United States stands out at the extreme end of the spectrum, and not in a good way.

The second need is for something as simple as an electronic health card—something that looks like a plastic credit card and can be carried in a wallet—that records a person’s valuable medical information, including recent surgeries. By far the most important fact about the collapsed workman was his lung surgery—and he couldn’t tell anyone about it and probably didn’t have a record of it on any document he carried. The emergency team might not have needed to know about the surgery to realize that he was, in effect, drowning and save him, but many times that kind of specific information can make a life-or-death difference.

Even though these types of cards have recently become feasible, health care providers are still stuck at the sophistication level of a supermarket. Providers will accept credit or debit cards for payment, but when it comes to health records, they rely on oral questioning or paper-and-pencil notes taken at the start of a consultation. Additionally, they often ask patients the same questions they just asked on the previous visit and to which they don’t seem to have saved the answers. When there’s no urgency, that obsolete information-collection procedure wastes time and contributes to inaccuracy and in turn can lead to medical errors. In an emergency, it isn’t just inefficient; it can be lethal.

Of course, if we had universal insurance and electronic health cards, we could still occasionally run into someone in a hospital who didn’t know how to respond to an emergency. But the chances would be lessened. It makes no sense to continue taking the risks, both medical and financial, that our system imposes when we know what it takes to control them.